DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Public Health
DPH 4723 (Rev. 05/01)

STATE OF WISCONSIN
ss. 255.075, Wis. Stats.

WISCONSIN WELL WOMAN PROGRAM (WWWP)
Breast Cancer Screening Activity Report (ARF)

Information and Instruction on reverse side

PERSONAL INFORMATION

1. Last Name	2. First Name	3. Middle Initial
4. Maiden Name	5. Date of birth (mm/dd/yyyy)	

6. Social Security Number (Optional) or Client Identification Number

BREAST SCREENING HISTORY

Check all that apply

7. Last Mammogram? ☐ Yes ☐ No ☐ Unknown

8. Date of last Mammogram (mm/dd/yyyy)_____

9. Provider / Clinic_____

10. Personal history of breast cancer? ☐ Yes ☐ No ☐ Unknown

11. Mastectomy? ☐ Yes ☐ No ☐ Unknown

12. If 11 is yes, which side? ☐ Right ☐ Left

13. Family history of breast cancer? ☐ Yes ☐ No ☐ Unknown

14. Client reports breast symptoms? ☐ Yes ☐ No ☐ Unknown

15. Was a Pap Smear done in last 12 months? ☐ Yes ☐ No ☐ Unknown

16. Was Pap Smear funded by WWWP? ☐ Yes ☐ No ☐ Unknown

CLINICAL BREAST EXAM

24. Was breast exam was completed? ☐ Yes ☐ No ☐ Refused by client

☐ Not done(Provider decision) give reason_____

25. Provider / Clinic_____

26. City where performed_____

27. Date performed (mm/dd/yyyy)_____

28. Check all that apply

RESULT

☐ Normal Exam
☐ Benign Finding (Fibrocystic changes)
☐ Discrete Palpable Mass**
☐ Bloody or Serous Nipple Discharge**
☐ Nipple or Areolar Scaliness**
☐ Skin dimpling or Retraction**

** Diagnostic testing is required.

29. Was breast exam paid by WWWP ☐ Yes ☐ No ☐ Unknown

MAMMOGRAM

17. What type of Mammogram was done
☐ Screening Mammogram ☐ Diagnostic Mammogram

18. Check apropriate box, if not done

☐ Refused by client
☐ Not done (Provider decision) give reason_____
☐ Done elsewhere
☐ Needed but not performed(excluding "refused by client")

19. Was Mammogram funded by WWWP? ☐ Yes ☐ No ☐ Unknown

20. Provider / Clinic_____

21. City where performed_____

22. Date performed (mm/dd/yyyy)_____

MAMMOGRAM RESULT

30. Radiologist_____

31. Radiologist location (i.e. city)_____

32. Check appropriate box

RESULT

☐ Negative findings
☐ Benign findings
☐ Probably benign – Short Term follow up
☐ Suspicious abnormality – consider biopsy**
☐ Highly suggestive of malignancy**
☐ Assessment incomplete (Findings requires additional imaging evaluation)**
☐ Unsatisfactory (Cannot be interpreted)

** Diagnostic testing required

BREAST SCREENING RECOMMENDATION

23. Recommendation(s)

☐ Follow Routine Screening schedule_____months.
☐ Short term follow up _____months _____procedure
☐ Diagnostic Mammogram
☐ Consultant's Breast Exam
☐ Ultrasound
☐ Surgical consultation
☐ Fine needle aspiration
☐ Biopsy
☐ **Other (MRI, etc)***

*** Not reimbursable with WWWP funds.**

NOTES

Return completed top copy of form only to: WWWP, P.O. Box 6645, Madison, WI 53716-0645

White (Top) Copy - WWWP **Yellow (2nd) Copy - Provider** **Pink (3rd) Copy - Local Coordinating Agency**

INSTRUCTIONS FOR WISCONSIN WELL WOMAN PROGRAM (WWWP)

Breast Cancer Screening Activity Report Form (ARF)

The Department of Health and Family Services has the authority to collect personally identifiable information necessary to determine eligibility for services for the WWWP. The personally identifiable information collected on this form will ONLY be used to determine eligibility for services and case management. Provision of the Social Security Number is optional.

PERSONAL INFORMATION

1. Print client's Last Name.
2. Print client's First Name.
3. Print client's Middle Initial.
4. Print client's Maiden Name, if applicable.
5. Indicate client's Date of Birth. Use numbers for month, day and year, i.e. 01/15/1935.
6. Indicate client's Social Security Number (SSN) or Client Identification Number (CIN). The SSN is optional and will be used to determine the client's eligibility for services and to identify her status with other healthcare programs. The Local Coordinating Agency will assign the CIN.

BREAST SCREENING HISTORY

7. Indicate if the client has ever received a Mammogram Prior to this date.
8. Indicate the Date of the client's last Mammogram. Use numbers for month, day and year, i.e. 01/15/2000.
9. Indicate the name of the Provider / Clinic where the last Mammogram was provided.
10. Indicate if the client has a Personal History of Breast Cancer.
11. Indicate if the client has had a Mastectomy.
12. Indicate which breast, if number 11 is Yes.
13. Indicate if the client has a Family History of Breast Cancer.
14. Indicate if client reported any Breast Symptoms at this visit.
15. Indicate whether a Pap test was done in the last 12 months.
16. Indicate whether that Pap test was funded by WWWP.

MAMMOGRAM

17. Indicate the type of Mammogram the client received
18. Check the appropriate box to indicate the status. If Provider decision not to complete indicate reason, i.e. breast exam without mammogram.
19. Indicate if the Mammogram was funded by WWWP
20. Indicate the name of the Provider / Clinic where the Mammogram was performed.
21. Indicate the City where the Provider / Clinic who performed the mammogram is located.
22. Indicate the Date the Mammogram was performed. Use numbers for month, day and year, i.e. 01/15/2000.

BREAST SCREENING RECOMMENDATION

23. Check the appropriate box to indicate the breast cancer screening recommendations. If Short Term Follow-up is recommended, indicate how many months and what procedure,

CLINICAL BREAST EXAM

24. Indicate if breast exam was completed. Check the appropriate box to indicate the status. If Provider decision not to complete indicate reason, i.e. CBE was already completed.
25. Indicate the name of the Provider / Clinic where the Clinical Breast Exam was performed.
26. Indicate the City where the provider who performed the Clinical Breast Exam is located.
27. Indicate the Date the Clinical Breast Exam was performed. Use numbers for month, day and year, i.e. 01/15/2000.
28. Check the appropriate box indicating results of the Clinical Breast Exam. NOTE: If any of the four boxes with double asterisk (**) are checked, a diagnostic test is required.
29. Indicate if the Clinical Breast Exam was funded by WWWP.

MAMMOGRAM RESULT

30. Indicate the name of the Radiologist where the Mammogram Results were determined.
31. Indicate the City where Radiologist who determined the Mammogram result is located.
32. Check the appropriate box to identify the results of the Mammogram. NOTE: If any of the four boxes with double asterisk (**) are checked, diagnostic testing is required.

Return completed form, White(Top) Copy Only to:

WWWP
P.O. Box 6645
Madison, WI 53716-0645